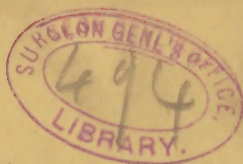


STEWART (R.W.)

Direct and oblique
inguinal = hernia on the same side





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**DIRECT AND OBLIQUE INGUINAL HERNIA ON
THE SAME SIDE.**

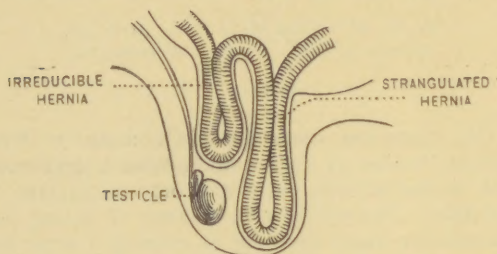
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J. M., thirty-five years old, was admitted to Mercy Hospital, October 23, 1892, suffering from a large scrotal hernia on the left side, which had been strangulated for three days. The patient gave a history of having been ruptured five years ago, and of wearing a truss since that time, until the present hernia descended into the scrotum and became strangulated. The characteristic symptoms of strangulation were present. The material vomited had a fecal odor, the pulse was rapid, and the general appearance of the patient indicated the near approach of collapse, and the urgency of immediate operative interference.

The patient was at once prepared for operation, in which I was assisted by my colleague, Dr. Buchanan, and the house-surgeon, Dr. Stelwagon. The man being anesthetized, and the pubes and scrotum shaved and rendered aseptic, the hernial sac was opened by a longitudinal incision extending from the external ring downward for a distance of five inches, and exposing the hernial contents, consisting of a coil of small intestine, about nine inches in length, which was quite black, but not gangrenous. The constriction, which was at the external ring, being divided, the gut was drawn downward, in order to examine the points of constriction and to assure ourselves of the vitality of the intestine before it was replaced within the abdomen.



At this time it was noticed that there was a peculiar bulging forward of the posterior wall of the sac, caused by a mass the nature of which it was difficult to determine. In order to perform the radical operation for hernia the sac was dissected up to the internal ring, exposing at the bottom of the wound the mass already



Diagrammatic representation of the relative position of the hernias to each other.

referred to. The weight of evidence was in favor of this mass being an old irreducible hernia, and a point was selected where, if it was a hernia, it was thought the sac would not be adherent to its contents. This was carefully incised, exposing within a coil of intestine, the walls of which were so thickened and its surface so altered by firm adhesions to the sac as to be almost unrecognizable. With considerable difficulty the adhesions were broken down. The finger could then be passed with facility between the gut and its sac, and the continuity of the latter with the parietal peritoneum demonstrated. When the gut was liberated from adhesion to its sac it became distended with gas. It was then replaced within the abdominal cavity.

The sacs of both herniæ were tied as high up as possible and cut off, and the common pedicle of both sacs was sutured to the pillars of the ring and the wound closed in the ordinary manner.

The subsequent course of the case was marked only by the development of an orchitis and sloughing of some of the connective-tissue bands that were torn in dissecting up the two hernial sacs.

The chief point of interest in this case is the presence on the same side of two inguinal herniæ, one of which was strangulated and the other not. The explanation given by Dr. Buchanan at the time of the operation seems the most rational one. He thought that the hernia that had been formed five years ago was a direct inguinal one, that it had never been reduced, though during this period the patient had constantly worn a truss. The gut in the meantime had, however, become firmly adherent to the sac. The strangulated hernia was probably of recent origin, and had descended obliquely through the inguinal canal.

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